

## **Appendix IV**

### **Sample Maternal Informed Consent**

**REMINDER TO STUDY SITES: Do not use the preamble in local consents.**

NOTE FROM THE OFFICE FOR HUMAN RESEARCH PROTECTIONS (OHRP) TO SITES ENROLLING PARTICIPANTS IN THIS STUDY:

Please note that this sample language does not preempt or replace local Institutional Review Board (IRB)/Institutional Ethics Committee (IEC) review and approval. Investigators are required to provide the local IRB/IEC with a copy of this sample language along with the language intended for local use. Local IRBs/IECs are required to weigh the unique risks, constraints and population considerations as a condition of any approval. Any deletion or substantive change of information concerning risks or alternative treatment must be justified by the investigator, approved by the local IRB/IEC and noted in the IRB/IEC minutes. Justification and IRB/IEC approval of such changes must be forwarded to Westat, or as may be otherwise specified. Sponsor-approved changes in a protocol must be approved by the local IRB/IEC before use unless intended for the elimination of apparent immediate hazard. New information shall be shared with existing participants at the next encounter, with all new participants prior to involvement or as the local IRB/IEC may otherwise additionally require.

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**TITLE OF STUDY:**                    **Prospective Cohort Study of HIV and Zika in Infants and Pregnancy (HIV ZIP)**

**Principal Investigator (PI):** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

### **Introduction**

This research study is sponsored by The *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) in the United States. This study is being done to see how Zika affects pregnant women with and without the Human Immunodeficiency Virus (HIV) and their babies. It is being done in Brazil, mainland United States and Puerto Rico.

You are being asked to join because:

- You are pregnant.
- You are at least 15 years old.
- You live in an area where people have Zika or you, someone you live with or a sexual partner has traveled to an area where people have Zika.

- You are either less than 18 weeks pregnant or you are 18 or more weeks pregnant and have symptoms of Zika.

Some women in this study may also have HIV.

This consent form will help you learn about this study. You can ask the study staff any questions you have about this study at any time. If you want to be in this study, you will be asked to sign this form. You will get a copy once signed.

It is important that you know:

- You choose/decide to be in this study or not.
- Your baby will be in this study once you deliver. You will need to sign another consent form for your baby.
- If you join this study, you can stop **at any time**. It will not affect any benefits you have, health care at the clinic or your ability to be in other studies.
- At any time, you can decide that we should not collect some or all of the study samples from you. If this happens, you may or may not still be in this study. Your samples are needed to test you for Zika.

### **What is Zika?**

Zika is a virus that can be passed from an infected mosquito bite. It can also be spread from a mother to her unborn child while she is pregnant and during delivery. Alternatively, it can be spread by sexual contact with a person that has Zika or through a transfusion with infected blood.

The most common symptoms of Zika are fever, rash, muscle, bone or joint pain, headaches and redness and swelling in the eyes. Most people have either very mild symptoms or no symptoms at all. Many people do not even know that they are infected.

Zika may cause severe problems for a baby, such as microcephaly. Microcephaly causes the baby's head to be very small, and keeps the brain from growing, as it should. There may be other serious problems with the baby's sight, hearing or growth. Some babies may not survive at or after birth.

### **Why is this Study Being Done?**

Excellent progress has been made in the care given to pregnant women with HIV and their babies. This has improved the health and life for both mothers and babies. It has also greatly lowered the chance that babies born to mothers with HIV will be infected themselves. The effect of Zika on the body's ability to fight HIV is unknown.

This study wants to understand the effect of Zika on the health of pregnant women who have HIV or Zika, or both HIV and Zika. It also wants to see if babies born to women who have HIV or Zika, or both together have different or worse problems than babies born to women who do not have either HIV or Zika. We will also check to see if mothers have any other infections that cause problems with their babies. The effect of Zika on the body's ability to fight HIV and other infections is unknown.

We do not know how many babies with Zika will have health problems, and what problems will occur. We do not know if Zika infection could make these problems worse. It is important to learn more about these things so that we can provide the best care and treatment for mothers and their babies with and without Zika and with and without HIV.

### **What Do I Have to Do If I Am in this Study?**

First, you will have a **Screening visit** to see if you can be in this study. If you can be in this study, you will then come for these visits:

- Entry visit (may be done on the same day as the Screening visit)
- Second Trimester visit (weeks 22-26 of pregnancy)
- Third Trimester visit (weeks 32-36 of pregnancy)
- Delivery visit (within 48 hours after birth)
- Six Weeks Post Delivery visit (5-7 weeks after birth)

Each visit will last about 1 hour and a half (1 ½ hours).

#### Screening Visit

The following activities will be done at the Screening visit:

- You will be asked about your age, background, the date of your last menstrual period and different ways that the staff can contact you.
- You will be asked if the research team can look at your medical records.
- You will be given a diary card to write down any Zika symptoms you have in between your study visits. You will be asked to bring your diary card to each visit.
- Results of any ultrasounds you have during your pregnancy will be taken from your medical record. If not already done through your usual prenatal care, you may have an ultrasound (a device that uses sound waves to see and measure your baby), or 1 ml (.2 teaspoon) of blood or urine collected to see if you are pregnant.
- If you are already 18 or more weeks pregnant and have signs of Zika, you will have up to 10 ml (2 teaspoons) of blood and urine collected for a Zika test. If the test shows that you do not have Zika, you cannot be in this study. If you cannot be in this study, you will still receive the same prenatal care that you would have received before.

The following activities will be done at all your other visits:

- You will learn about how to prevent Zika and the signs and symptoms of infection. You will be asked to tell the study staff right away, if you, a sexual partner or someone you live with have any of these symptoms.
- You will have a physical exam that includes your weight and temperature. Your health care provider will check you for any signs of Zika. Your health care provider may decide that you need more exams.
- You will be asked about your health, medications you have taken, any pregnancy symptoms, your work and home, and drug and alcohol use.
- You will be asked about Zika symptoms and your diary card will be reviewed.
- You may have an ultrasound if one was not already done through your regular prenatal care.
- If you have HIV, results from HIV tests done during your pregnancy will be taken from your medical record.
- You may have up to 20 ml (4 teaspoons) of blood and urine collected to test for Zika and possibly other infections like it (such as dengue and chikungunya) that may cause symptoms like Zika.

#### Delivery Visit

The following will also be done at your Delivery visit:

- You may have up to 20 ml (4 teaspoons) of blood taken from the umbilical cord after it is cut.
- A small amount of tissue will be taken from your placenta after it is delivered.

If you have a miscarriage or if your baby is not alive at birth, we will collect the umbilical cord blood and placenta tissue.

#### If You Develop Zika-like Symptoms While in this Study

You will be asked to come for an extra study visit if you develop any symptoms of Zika.

At this visit:

- You will have a physical exam that includes your weight and temperature.
- You will be asked about your health, medications you have taken, any pregnancy symptoms, your work and home, and drug and alcohol use.
- You will be asked about Zika symptoms and your diary card will be reviewed.
- Results from your last ultrasound will be taken from your medical record and reviewed.
- You may have up to 16 ml (about 3 teaspoons) of blood and urine collected to test for Zika and possibly other infections like it (such as dengue and chikungunya) that may cause symptoms like Zika.

- We will schedule an appointment for you to discuss the Zika test results.

Since the study staff will let you know the results of tests done during this study, it is important that you tell them about any changes in how to reach you.

### **How Many Pregnant Women Will Be in this Study?**

This study will be done in two parts. The first part will enroll 200 pregnant women. If 200 women are enrolled, the second part will enroll up to another 1,800 pregnant women.

### **How Long Will I Be in this Study?**

You will be in this study for less than one year.

### **What Are the Risks of this Study to Me?**

#### Risks While Collecting Blood

You may feel faint or feel some pain while having blood taken. There may be some tenderness, swelling, bleeding, bruising or a small risk of infection at the point where the needle goes into the skin. A small, brief blood clot may develop. To reduce these risks, trained staff will take your blood.

#### Other Possible Risks

You may be uncomfortable being asked about your health, sexual activity, or alcohol or drug use. You will be answering these questions in a private room with trained staff. Your answers will be kept confidential (private). We can refer you to someone to talk to if you become very upset while answering questions.

You may become upset if you learn you have Zika. There will be a counselor for you to talk to at this time. He/she can help you learn more about Zika. You may choose to bring a friend or family member with you to the counseling session.

### **What Are the Benefits of Taking Part in this Study?**

There may be no direct benefits for you from being in this study. You will get the results of all Zika tests done during this study. This information may help inform you and your doctor's choices about your pregnancy and health care. The information learned from this study may also help doctors provide better care for mothers and babies with HIV and Zika in the future.

## How Will My Privacy and Confidentiality Be Protected?

The doctors and research staff will work to keep your information confidential [BRAZIL: INSERT THE FOLLOWING AT THE END OF THE SENTENCE: according to Brazilian and International rules]. Study staff sign a form promising to protect your information. Your name will be replaced by a special code called a Participant Identification (PID) number. The code will be used on your study samples and all your study forms to protect your identity. The link between your code and your name will be kept in a locked place at the research site, separate from your medical chart. Paper files will also be kept in a locked place at the research site. Computer files will be password protected. Access to all study information will be limited to people working on this study. Nothing written or published about this study will use your name.

[NOT APPLICABLE FOR BRAZIL: To help further protect your information, a Certificate of Confidentiality will be obtained from the U.S. Department of Health and Human Services. This document protects the study staff from having to share your information when asked during Federal, State, or local civil, criminal, administrative, legislative or other proceedings.

A Certificate of Confidentiality does not prevent you from giving your permission to share your information if you choose. If someone (like an insurer or employer) requests your laboratory results or other research information and you say it is okay, the study staff cannot use the Certificate of Confidentiality to prevent you from sharing it. This means that you must be careful about whom you choose to allow to look at your research information.]

Groups in the United States such as the National Institutes of Health (NIH), Office for Human Research Protections (OHRP), study monitors and the [INSERT IRB/IEC NAME] may look at your information. They make sure your rights and safety are protected.

[BRAZIL: INSERT THE FOLLOWING: When agreed on by the study doctor and staff, and complying with the Code of Ethics of the Federal Counsel of Medicine and Brazilian laws that protect study participants, your information may be looked at by the Ethics Committee of the Ministry of Health, and other agencies in your country that also make sure your rights and safety are protected.]

Every effort will be made to keep your participation and your personal information in your research record confidential, but absolute confidentiality cannot be guaranteed. This includes reporting infectious diseases to health authorities as required by local law. Another example is, if we learn something that would immediately put you or others in danger, the study staff are required by law to take steps to keep you and others safe. This means that we have to report to the authorities (hospital, police or social services) any information you tell us that suggests that you might be in danger, such as if you tell us that you plan to hurt or kill yourself, hurt or kill someone else or if you tell us that someone is abusing or neglecting you.

[PEDIATRIC HIV/AIDS COHORT STUDY (PHACS) SURVEILLANCE MONITORING FOR ART TOXICITIES (SMARTT) SITES ONLY (FOR HIV-INFECTED WOMEN ONLY)

INSERT THE FOLLOWING: If you also decide to participate in the Pediatric HIV/AIDS Cohort Study Surveillance Monitoring for Antiretroviral Therapy Toxicities (PHACS SMARTT) study, your information from HIV ZIP (this study) will be shared with PHACS SMARTT. All information, once shared, will be protected just as it is for HIV ZIP.]

A description of this study will be available on the website: <http://clinicaltrials.gov>. The description will include a summary of the results. There will be no information that could identify you. You can search this website at any time.

### **What Are the Costs to Me?**

There are no costs to you in this study. You will not pay for the study visits, physical exams or tests done for this study. You or your insurance company will still pay for any medical care that is not part of this study.

### **Will I Receive Any Payment?**

You [will/will not] be paid for your time during the study visits. You [will/will not] receive money for the cost of food and transportation. [INSERT ANY SITE-SPECIFIC COMPENSATION DETAILS]. Some research may lead to new things, such as new medicines or tests. You will not receive any money from these new medicines or tests.

### **Are There Options to Being in this Study?**

You may choose not to join this study. If you wish, we can tell you if there are other studies we know about that you can join.

### **What Happens If I Am Injured?**

We do not think that you will be injured because of this study. If you are injured, you will be treated for your injuries related to this study for as long as needed at no cost to you [BRAZIL: INSERT AS APPLICABLE: as well as paid for possible indemnities]. [U.S.: INSERT AS APPLICABLE: The cost for this treatment will be charged to you or your insurance company.]

The doctor in charge of this study at our site, [INSERT PI NAME], is responsible for making sure you get this care. You will not receive any money through NICHD (the study Sponsor). You will not be giving up any of your legal rights by signing this consent form.

## **What Are My Rights as a Research Participant?**

The choice to be in this study is yours, meaning it is voluntary. You will be told about new information from this or other studies that may affect your decision to stay in this study. Your decision will not affect whether or not you can be in other studies. It will not take away any of your benefits. Tell the study staff if you want to know about the results of this study.

## **Can I Be Taken Off this Study Early?**

The study doctor may take you off this study early without your permission for the following reasons:

- The doctor thinks you could be harmed from being in this study. The doctor will inform the [INSERT IRB/IEC NAME] IRB/IEC of his/her decision. The [INSERT IRB/IEC NAME] IRB/IEC is in charge of protecting the safety and rights of the research participants at this site.
- This study is stopped by NICHD, OHRP, this site's IRB/IEC, or other governmental agencies [BRAZIL: INSERT THE FOLLOWING: or the Brazilian National IRB CONEP].
- You are not able to come to the study visits or complete the study evaluations.

If you are taken off this study, no more information will be collected from you and no more study visits will be done. The information that you already gave us will stay in this study.

## **What If I Have Problems or Questions?**

If you have problems with or questions about this study, or in case of harm due to this study, contact [INSERT NAME AND PHONE NUMBER OF PI] or [INSERT NAME AND PHONE NUMBER OF IRB/IEC CONTACT]. The local IRB or IEC is located in [INSERT INSTITUTION NAME, ADDRESS AND PHONE NUMBER], and the hours of operation are [INSERT HOURS OF OPERATION].

## **Storage of Samples**

Researchers in this study would also like to store your samples for possible future research. Some of the research may be done to find better tests for Zika. Some of the research may be done to better understand how Zika may cause disease and problems, and how to best treat or prevent Zika and the problems it can cause.

If any of your blood and urine are left after the tests have been done for this study, they will be stored for future research with your permission. We will also ask to collect some extra blood, urine, a piece of your placenta and blood from the umbilical cord to store for future research.



They will all be kept in a special laboratory called a Biorepository. The Biorepository for this study is located in the United States (Fisher BioServices).

[NOT APPLICABLE FOR BRAZIL: Researchers may want to look at how people's genetic makeup (their DNA) either protects them or puts them at greater risk for Zika. Information from DNA testing will be very important as scientists work to better protect and treat people with Zika.]

Your samples will be labeled with your study code only. The document that is locked at the research site that links this code to your name will not be available to anyone at the Biorepository and researchers who may use your samples. Only people who work at the Biorepository and researchers will have access to your stored samples. They will not be sold or used to make products that can be sold for money.

If researchers want to use your stored samples, they will need permission from NICHD. [BRAZIL: INSERT THE FOLLOWING: They will also need permission from the site's IRB/IEC. According to the Brazilian rules, your samples will be kept stored for up to five years. If the researchers want to keep your samples for a longer time, they must provide a report to their local IRB/IEC that tells about what they plan to do with the samples.]

[NOT APPLICABLE FOR BRAZIL: You will not receive the results of research done with samples from the Biorepository. This is because samples can stay in the Biorepository for many years. There is no time limit to when studies could be done in the future. The results of these future studies will not affect your care right now, but they may help people like you in the future.]

You may decide that you do not want your samples to be stored for future research studies. You can still participate in this study even if you make this decision.

**Please indicate your response to the following statement and initial in the appropriate space provided.**

I agree to allow my blood samples to be stored for use in future NICHD, [BRAZIL: INSERT THE FOLLOWING: and CEP/CONEP system] approved related research studies.

Check one:

☐ **Yes**      ☐ **No**      \_\_\_\_\_ Initials      \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date

**If Study Participant's Parent/Legal Guardian is Illiterate**

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Thumbprint of Participant's  
Parent/Legal Guardian



[BRAZIL: INSERT THE FOLLOWING: **Please indicate your response to the following statement and initial in the appropriate space provided.**

I wish to be informed about every new future research study approved by the NICHD research network and the CEP/CONEP for researcher use of my blood samples through a new Informed Consent.

Check one:

☐ **Yes**      ☐ **No**      \_\_\_\_\_ Initials      \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date

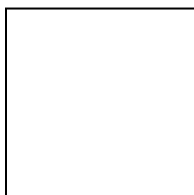
**If Study Participant's Parent/Legal Guardian is Illiterate**

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Thumbprint of Participant's  
Parent/Legal Guardian]



**[NOT APPLICABLE IN BRAZIL: Please indicate your response to the following statement and initial in the appropriate space provided.]**

I consent (agree) to allow samples to be stored for use in future studies that will use my DNA and are approved by NICHD.

Check one:

☐ **Yes**      ☐ **No**      \_\_\_\_\_ Initials      \_\_\_\_/\_\_\_\_/\_\_\_\_ Date

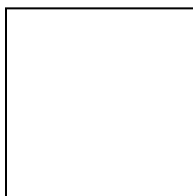
**If Study Participant's Parent/Legal Guardian is Illiterate**

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Thumbprint of Participant's  
Parent/Legal Guardian]



**A copy of this Informed Consent Form has been provided to the participant's parent(s) or legal guardian(s): \_\_\_\_\_ (initialed by Study Personnel).**

## AUTHORIZATION FOR ACCESSING INFORMATION FROM YOUR MEDICAL CHART

During your participation in this study, the responsible researcher will need access to information in your medical charts. **Please indicate your response to the following statement and initial in the appropriate space provided.**

I authorize the study investigator to access information in my medical charts.

Check one:

☐ **Yes**      ☐ **No**      \_\_\_\_\_ Initials      \_\_\_\_/\_\_\_\_/\_\_\_\_ Date

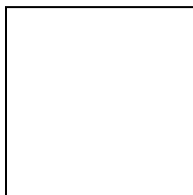
### If Study Participant's Parent/Legal Guardian is Illiterate

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Thumbprint of Participant's  
Parent/Legal Guardian



\_\_\_\_\_  
Name of Study Personnel

\_\_\_\_\_  
Signature of Study Personnel

\_\_\_\_\_  
Date

## Statement of Consent

The purpose of this research study, what you will be asked to do and the risks and benefits of this study have been explained to you. Any questions you have about this study have been answered. You have been told that participation in this study is voluntary. It is your choice to take part in this study. You may refuse to take part or may stop taking part at any time without it affecting your future treatment at this hospital/clinic, or your relations with the hospital/clinic or its employees.

*(NOTE: This is only a suggested signature format. Sites may use their own signature page.)*

By signing this consent document, you are agreeing to take part in this study. You will be given a copy of this signed consent form to keep.

_____	_____	_____
Participant's Name (print)	Participant's Signature	Date

## PI or Designee's Statement:

I have reviewed this study and the consent form with the participant. To the best of my knowledge, the participant understands the purpose, procedures, risks and benefits of this study.

_____	_____	_____
PI or Designee's Name (print)	PI or Designee's Signature	Date

_____	_____	_____
Witness's Name (print)	Witness's Signature	Date

NOTE: This consent form with the original signatures MUST be retained on file by the PI. A copy must be given to the participant. A copy should be placed in the participant's medical record, if applicable.

**If Study Participant is Illiterate**

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions and has indicated that she understands the information given to her. I confirm that the individual has given consent freely.

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Thumbprint of Participant



I have accurately read or witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions and has indicated that she understands the information given to her. I confirm that the individual has given consent freely.

\_\_\_\_\_  
Name of Study Personnel

\_\_\_\_\_  
Signature of Study Personnel

\_\_\_\_\_  
Date

**A copy of this Informed Consent Form has been provided to the participant/parent(s) or legal guardian(s) of the participant: \_\_\_\_\_ (initialed by Study Personnel).**